



General Assembly

January Session, 2019

Amendment

LCO No. 8828



Offered by:

SEN. LOONEY, 11th Dist.

SEN. LESSER, 9th Dist.

To: Senate Bill No. 33

File No. 307

Cal. No. 161

"AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED PRESCRIPTION DRUGS."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Subsection (d) of section 38a-504 of the general statutes is
4 repealed and the following is substituted in lieu thereof (*Effective*
5 *January 1, 2020*):

6 (d) (1) Each policy of the type specified in subsection (a) of this
7 section [that] shall:

8 (A) If such policy provides coverage for intravenously administered
9 and orally administered anticancer medications used to kill or slow the
10 growth of cancerous cells that are prescribed by a prescribing
11 practitioner, as defined in section 20-571, [shall] provide coverage for
12 orally administered anticancer medications on a basis that is no less

13 favorable than intravenously administered anticancer medications;
14 and

15 (B) If such policy provides coverage for intravenously administered
16 and orally administered medications used to treat disabling or life-
17 threatening chronic diseases that are prescribed by a prescribing
18 practitioner, as defined in section 20-571, provide coverage for such
19 orally administered medications on a basis that is no less favorable
20 than such intravenously administered medications if such orally
21 administered medications are approved by the federal Food and Drug
22 Administration for such treatment.

23 (2) No insurance company, hospital service corporation, medical
24 service corporation, health care center or fraternal benefit society that
25 delivers, issues for delivery, renews, amends or continues in this state
26 a policy of the type specified in subsection (a) of this section shall
27 reclassify [such anticancer] medications that are subject to subdivision
28 (1) of this subsection or increase the coinsurance, copayment,
29 deductible or other out-of-pocket expense imposed under such policy
30 for such medications to achieve compliance with this subsection.

31 Sec. 2. Subsection (d) of section 38a-542 of the general statutes is
32 repealed and the following is substituted in lieu thereof (*Effective*
33 *January 1, 2020*):

34 (d) (1) Each policy of the type specified in subsection (a) of this
35 section [that] shall:

36 (A) If such policy provides coverage for intravenously administered
37 and orally administered anticancer medications used to kill or slow the
38 growth of cancerous cells that are prescribed by a prescribing
39 practitioner, as defined in section 20-571, [shall] provide coverage for
40 orally administered anticancer medications on a basis that is no less
41 favorable than intravenously administered anticancer medications;
42 and

43 (B) If such policy provides coverage for intravenously administered

44 and orally administered medications used to treat disabling or life-
45 threatening chronic diseases that are prescribed by a prescribing
46 practitioner, as defined in section 20-571, provide coverage for such
47 orally administered medications on a basis that is no less favorable
48 than such intravenously administered medications if such orally
49 administered medications are approved by the federal Food and Drug
50 Administration for such treatment.

51 (2) No insurance company, hospital service corporation, medical
52 service corporation, health care center or fraternal benefit society that
53 delivers, issues for delivery, renews, amends or continues in this state
54 a policy of the type specified in subsection (a) of this section shall
55 reclassify [such anticancer] medications that are subject to subdivision
56 (1) of this subsection or increase the coinsurance, copayment,
57 deductible or other out-of-pocket expense imposed under such policy
58 for such medications to achieve compliance with this subsection.

59 Sec. 3. Section 38a-472g of the general statutes is repealed and the
60 following is substituted in lieu thereof (*Effective January 1, 2020*):

61 (a) (1) No insurer, health care center, fraternal benefit society,
62 hospital service corporation or medical service corporation or other
63 entity, delivering, issuing for delivery, renewing, amending or
64 continuing an individual or group health insurance policy in this state
65 providing coverage of the type specified in subdivisions (1), (2), (4),
66 (11) and (12) of section 38a-469 or utilization review company
67 performing utilization review for such insurer, center, society,
68 corporation or entity, that:

69 (A) On or after January 1, 2012, issues prior authorization for, or
70 precertifies, [on or after January 1, 2012,] an admission, service,
71 procedure or extension of stay shall reverse or rescind such prior
72 authorization or precertification or refuse to pay for such admission,
73 service, procedure or extension of stay if:

74 [(A)] (i) Such insurer, center, society, corporation, entity or company
75 failed to notify the insured's or enrollee's health care provider at least

76 three business days prior to the scheduled date of such admission,
77 service, procedure or extension of stay that such prior authorization or
78 precertification has been reversed or rescinded on the basis of medical
79 necessity, fraud or lack of coverage; and

80 [(B)] (ii) Such admission, service, procedure or extension of stay has
81 taken place in reliance on such prior authorization or precertification;
82 and

83 (B) On or after January 1, 2020, issues prior authorization for, or
84 precertifies, an admission, service, procedure or extension of stay shall
85 impose any requirement in determining whether to issue prior
86 authorization for, or precertify, an admission, service, procedure or
87 extension of stay if such requirement is unrelated to the determination
88 of whether such admission, service, procedure or extension of stay is
89 medically necessary, as defined in section 38a-482a, as amended by
90 this act, or 38a-513c, as amended by this act, as applicable.

91 (2) The provisions of this subsection shall apply regardless of
92 whether such prior authorization or precertification is required or is
93 requested by an insured's or enrollee's health care provider. Unless
94 reversed or rescinded as set forth in subparagraph (A)(i) of subdivision
95 (1) of this subsection, such prior authorization or precertification shall
96 be effective for not less than sixty days from the date of issuance.

97 (b) Nothing in subsection (a) of this section shall be construed to
98 authorize benefits or services in excess of those that are provided for in
99 the insured's or enrollee's policy or contract.

100 (c) Nothing in subsection (a) of this section shall affect the
101 provisions of subsection (b) of section 38a-479b.

102 Sec. 4. Section 38a-482a of the general statutes is repealed and the
103 following is substituted in lieu thereof (*Effective January 1, 2020*):

104 (a) For the purposes of this section:

105 (1) "Emergency medical condition" has the same meaning as

106 provided in section 38a-591a;

107 (2) "Emergency services" has the same meaning as provided in
108 section 38a-591a;

109 (3) "Generally accepted standards of medical practice" means
110 standards that are based on credible scientific evidence published in
111 peer-reviewed medical literature generally recognized by the relevant
112 medical community or otherwise consistent with the standards set
113 forth in policy issues involving clinical judgment;

114 (4) "Health care services" means services for the diagnosis,
115 prevention, treatment, cure or relief of a health condition, illness,
116 injury or disease, including, but not limited to, emergency services
117 with respect to an emergency medical condition;

118 (5) "Medically necessary" or "medical necessity" means health care
119 services that:

120 (A) A physician, exercising prudent clinical judgment, would
121 provide to a patient, without regard to:

122 (i) The financial interests of the insurer, health care center, fraternal
123 benefit society, hospital service corporation, medical service
124 corporation or other entity that delivered, issued for delivery,
125 renewed, amended or continued the policy providing coverage for
126 such services;

127 (ii) Whether such services are provided to the patient by a particular
128 type of licensed health care provider, provided such provider may
129 provide such services within such provider's scope of practice;

130 (iii) Whether such services are provided to the patient in a particular
131 type of licensed health care facility, provided such services may be
132 provided in such facility in accordance with applicable law; or

133 (iv) Whether such services are subsequently determined not to be
134 emergency services;

135 (B) Are in accordance with generally accepted standards of medical
136 practice;

137 (C) Are clinically appropriate, in terms of type, frequency, extent
138 and duration, and considered effective for a patient's health condition,
139 illness, injury or disease; and

140 (D) Not provided primarily for the convenience of a patient,
141 physician or another health care provider.

142 [(a)] (b) No insurer, health care center, fraternal benefit society,
143 hospital service corporation, medical service corporation or other
144 entity delivering, issuing for delivery, renewing, continuing or
145 amending any individual health insurance policy providing coverage
146 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12)
147 of section 38a-469 in this state shall: [deliver]

148 (1) Deliver or issue for delivery in this state any such policy unless
149 such policy contains [a] the definition of "medically necessary" or
150 "medical necessity" [as follows: "Medically necessary" or "medical
151 necessity" means health care services that a physician, exercising
152 prudent clinical judgment, would provide to a patient for the purpose
153 of preventing, evaluating, diagnosing or treating an illness, injury,
154 disease or its symptoms, and that are: (1) In accordance with generally
155 accepted standards of medical practice; (2) clinically appropriate, in
156 terms of type, frequency, extent, site and duration and considered
157 effective for the patient's illness, injury or disease; and (3) not primarily
158 for the convenience of the patient, physician or other health care
159 provider and not more costly than an alternative service or sequence of
160 services at least as likely to produce equivalent therapeutic or
161 diagnostic results as to the diagnosis or treatment of that patient's
162 illness, injury or disease. For the purposes of this subsection, "generally
163 accepted standards of medical practice" means standards that are
164 based on credible scientific evidence published in peer-reviewed
165 medical literature generally recognized by the relevant medical
166 community or otherwise consistent with the standards set forth in

167 policy issues involving clinical judgment] set forth in subsection (a) of
168 this section; or

169 (2) Deny coverage for health care services solely because such
170 insurer, center, society, corporation or entity retrospectively
171 determines that such services were not medically necessary emergency
172 services.

173 [(b)] (c) The provisions of [subsection (a) of] this section shall not
174 apply to any insurer, health care center, fraternal benefit society,
175 hospital service corporation, medical service corporation or other
176 entity that has entered into any national settlement agreement until the
177 expiration of any such agreement.

178 Sec. 5. Section 38a-513c of the general statutes is repealed and the
179 following is substituted in lieu thereof (*Effective January 1, 2020*):

180 (a) For the purposes of this section:

181 (1) "Emergency medical condition" has the same meaning as
182 provided in section 38a-591a;

183 (2) "Emergency services" has the same meaning as provided in
184 section 38a-591a;

185 (3) "Generally accepted standards of medical practice" means
186 standards that are based on credible scientific evidence published in
187 peer-reviewed medical literature generally recognized by the relevant
188 medical community or otherwise consistent with the standards set
189 forth in policy issues involving clinical judgment;

190 (4) "Health care services" means services for the diagnosis,
191 prevention, treatment, cure or relief of a health condition, illness,
192 injury or disease, including, but not limited to, emergency services
193 with respect to an emergency medical condition;

194 (5) "Medically necessary" or "medical necessity" means health care
195 services that:

196 (A) A physician, exercising prudent clinical judgment, would
197 provide to a patient, without regard to:

198 (i) The financial interests of the insurer, health care center, fraternal
199 benefit society, hospital service corporation, medical service
200 corporation or other entity that delivered, issued for delivery,
201 renewed, amended or continued the policy providing coverage for
202 such services;

203 (ii) Whether such services are provided to the patient by a particular
204 type of licensed health care provider, provided such provider may
205 provide such services within such provider's scope of practice;

206 (iii) Whether such services are provided to the patient in a particular
207 type of licensed health care facility, provided such services may be
208 provided in such facility in accordance with applicable law; or

209 (iv) Whether such services are subsequently determined not to be
210 emergency services;

211 (B) Are in accordance with generally accepted standards of medical
212 practice;

213 (C) Are clinically appropriate, in terms of type, frequency, extent
214 and duration, and considered effective for a patient's health condition,
215 illness, injury or disease; and

216 (D) Not provided primarily for the convenience of a patient,
217 physician or another health care provider.

218 [(a)] (b) No insurer, health care center, hospital service corporation,
219 medical service corporation or other entity delivering, issuing for
220 delivery, renewing, continuing or amending any group health
221 insurance policy providing coverage of the type specified in
222 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this
223 state shall: [deliver]

224 (1) Deliver or issue for delivery in this state any such policy unless

225 such policy contains [a] the definition of "medically necessary" or
226 "medical necessity" [as follows: "Medically necessary" or "medical
227 necessity" means health care services that a physician, exercising
228 prudent clinical judgment, would provide to a patient for the purpose
229 of preventing, evaluating, diagnosing or treating an illness, injury,
230 disease or its symptoms, and that are: (1) In accordance with generally
231 accepted standards of medical practice; (2) clinically appropriate, in
232 terms of type, frequency, extent, site and duration and considered
233 effective for the patient's illness, injury or disease; and (3) not primarily
234 for the convenience of the patient, physician or other health care
235 provider and not more costly than an alternative service or sequence of
236 services at least as likely to produce equivalent therapeutic or
237 diagnostic results as to the diagnosis or treatment of that patient's
238 illness, injury or disease. For the purposes of this subsection, "generally
239 accepted standards of medical practice" means standards that are
240 based on credible scientific evidence published in peer-reviewed
241 medical literature generally recognized by the relevant medical
242 community or otherwise consistent with the standards set forth in
243 policy issues involving clinical judgment] set forth in subsection (a) of
244 this section; or

245 (2) Deny coverage for health care services solely because such
246 insurer, center, society, corporation or entity retrospectively
247 determines that such services were not medically necessary emergency
248 services.

249 [(b)] (c) The provisions of [subsection (a) of] this section shall not
250 apply to any insurer, health care center, fraternal benefit society,
251 hospital service corporation, medical service corporation or other
252 entity that has entered into any national settlement agreement until the
253 expiration of any such agreement.

254 Sec. 6. Section 38a-478r of the general statutes is repealed and the
255 following is substituted in lieu thereof (*Effective January 1, 2020*):

256 (a) Each provider, as defined in section 38a-478, shall code for the

257 presenting symptoms of all emergency claims and each hospital shall
 258 record such code for such claims on locator 76 on the UB92 form or its
 259 successor.

260 (b) The presenting symptoms, as coded by the provider and
 261 recorded by the hospital on the UB92 form or its successor, or the final
 262 diagnosis, whichever [reasonably] indicates an emergency medical
 263 condition, as defined in section 38a-591a, shall be the basis for
 264 reimbursement or coverage, [, provided such symptoms reasonably
 265 indicated an emergency medical condition.]

266 [(c) For the purposes of this section, in accordance with the National
 267 Committee for Quality Assurance, an emergency medical condition is
 268 a condition such that a prudent layperson, acting reasonably, would
 269 have believed that emergency medical treatment is needed.]

270 [(d)] (c) The [Insurance Commissioner] commissioner may develop
 271 and disseminate to hospitals in this state a claims form system that will
 272 ensure that all hospitals consistently code for the presenting and
 273 diagnosis symptoms on all emergency claims."

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>January 1, 2020</i>	38a-504(d)
Sec. 2	<i>January 1, 2020</i>	38a-542(d)
Sec. 3	<i>January 1, 2020</i>	38a-472g
Sec. 4	<i>January 1, 2020</i>	38a-482a
Sec. 5	<i>January 1, 2020</i>	38a-513c
Sec. 6	<i>January 1, 2020</i>	38a-478r